STATE OF ARKANSAS
Department of Finance and Administration

OFFICE OF ADMINISTRATIVE SERVICES
Human Resources
1515 West Seventh Street, Suite 102
Post Office Box 2485
Little Rock, Arkansas 72203-2485
Phone: (501) 324-9065
Fax: (501) 683-2174
www.state.ar.us/dfa

MEMORANDUM

TO: *SUPERVISOR'S NAME:* _____
OFFICE NAME: _____
ADDRESS: _____
TELEPHONE NUMBER: _____

FROM: GERI JONES, DFA HUMAN RESOURCES

DATE: _____

SUBJECT: PROCEDURES FOR FILING WORKERS' COMPENSATION CLAIMS

RE: INSURED EMPLOYEE_____
SOCIAL SECURITY NUMBER_____

IMPORTANT: Complete and forward the attached forms (typewritten or printed in ink) within one working day of receipt to: GERI JONES, DFA HUMAN RESOURCES, P.O. BOX 2485, ROOM 101, 1515 BUILDING, LITTLE ROCK, AR 72203.

1. FORM 1A-1 - WORKERS COMP – FIRST REPORT OF INJURY. Supervisor completes.

2. FORM PECD 1 - EMPLOYEE'S NOTICE OF ACCIDENT. Employee completes.

3. FORM PECD 2 - WORKERS COMP INFORMATION SHEET. Supervisor completes.

4. FORM AR-N - EMPLOYEE'S NOTICE OF INJURY. Employee completes.

5. FORM AR-S - SUPPLEMENTAL REPORT. Supervisor completes.

6. MILEAGE REIMBURSEMENT FORM (MEDICAL MILEAGE). Employee completes.

IMPORTANT: Geri Jones will forward the completed forms to Public Employees Claims, who will gather any and all additional information, doctors' reports, etc., needed for determining and processing the claim.

NOTE: SEND ALL FUTURE MEDICAL BILLS, ETC., DIRECTLY TO PUBLIC EMPLOYEE CLAIMS DIVISION, 1200 WEST THIRD STREET, SUITE 201, LITTLE ROCK, AR 72201-1904.